MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00454

Reg. Diat. No. 150

1. PLACE OF DEATH:

County: Cecil

City or town: Port Deposit Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 month

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: Port Deposit, rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME 525 Richard H. Amson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 15. 1944

8. AGE: Years | Months: 3 | Days: 25 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Elkton Cecil Co. Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name: Edwin Cornish

13. Birthplace: Port Deposit

MOTHER — 14. Maiden name: Beatrice Amson

15. Birthplace: Port Deposit

16. Informant: Beatrice Amson

Address: Port Deposit. Md. R. F. D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 12 1947 (month) (day) (year)

Cemetery or crematory: Hosanna Harford Co

Location: Darlington Harford Co.

18. Funeral director: J. E. Tyson

Address: Rising Sun Md.

19. Jan 12 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1-10 19 47, at 4:05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1 19 46, to Jan 10 19 47

and that I last saw h.i.m alive on 1-9 19 47

Immediate cause of death	DURATION
Pneumonia	48 hrs.
Bronchial	
Due to: Malnutrition	
Due to:	
Other conditions: Premature birth	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Port Deposit Md. Date signed 1-11-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

00455

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: Cecil

City or town: Port Deposit

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 Years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Port Deposit

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Annie Virginia Blackburn

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Clifton M. Blackburn

6.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): July 1, 1877

8. AGE: Years	Months	Days	If less than one day
69	6	0	...hrs. ...min.

9. Birthplace: Cecil Co., Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: George Dutton Lynch

13. Birthplace: Cecil Co., Md.

MOTHER 14. Maiden name: Maria Howard

15. Birthplace: Cecil Co., Md.

16. Informant: Clifton M. Blackburn

Address: Port Deposit, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 4, 1947 (month) (day) (year)

Cemetery or crematory: Hopewell

Location: Port Deposit, Md., Rural

18. Funeral director: Wm. A. Patterson & Son

Address: Perryville, Md.

19. Jan. 3 1947 (Date rec'd by registrar) Irene E. Doughty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1-1 1947, at 6:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1946, to 1-1 1947 and that I last saw h... alive on 1-1- 1947

Immediate cause of death	DURATION
Coronary	
Thrombosis	
Due to Hypertension Cardiac	3 months
Vascular disease with	about
Due to Coronary Sclerosis.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W. M. Blackburn M.D.
M. D. or other

Address: Port Deposit Md. Date signed 1-3-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

47 00456

Reg. Dist. No. 92

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Cecil County

City or town Elkton (Rural- Cherry Hill).
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 21 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Cecil

City or town rural - Elkton RD 5 Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mollie E Brown

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Taylor A Brown

6(c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) May 20 1893

8. AGE: Years 53 | Months 8 | Days 11 | If less than one day ____ hrs. ____ min.

9. Birthplace Big Elk Md (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name George Buchanan

13. Birthplace Maryland

MOTHER 14. Maiden name Margaret Thell

15. Birthplace Penna

16. Informant Taylor A Brown

Address Elkton RD 5 Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 4 - 1947 (month) (day) (year)

Cemetery or crematory St Johns

Location Elkton RD 5 Md

18. Funeral director Joseph R. Frazer

Address North East Md

19. Feb 3 1947 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 31 Jan 1947, at 1 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10 Oct 1946 to 31 Jan 1947, and that I last saw h alive on 30 Jan 1947

Immediate cause of death	DURATION
Starvation.	1 mo.
Due to Pancreas, Carcinoma of	3 mo +
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations Carcinoma of Pancreas
Confirmed by Biopsy of pancreas.
Of autopsy none.

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Wallace M Johnson M.D.
M. D. or other

Address Newark Delaware Date signed 31 Jan 47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

107 * 00457

CERTIFICATE OF DEATH

Reg. Diat. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Cecil.
City or town: Elk Mills (If outside city or town limits, write RURAL and give nearest town)
Street No.: Md. (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Katherine Louise Chadwick

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Wh	Single

8.(b) Name of husband or wife:
8.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.):

8. AGE: Years	Months	Days	If less than one day
0	6	0	hrs. min.

9. Birthplace: Wilmington, Del. (Town, county, and state)
10. Usual occupation:
11. Industry or business
FATHER 12. Name: Dennis Chadwick
13. Birthplace: Cecil Co. Md
MOTHER 14. Maiden name: Katherine Rebecca Moore
15. Birthplace: Chesapeake City, Md
16. Informant: Mr. Dennis Chadwick
Address: Elk Mills, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 22 /47 (month) (day) (year)
Cemetery or crematory: Elkton
Location: Elkton Md
18. Funeral director: H W Tippin
Address: Elkton, Md.
19. Jan 22 1947 (Date rec'd by registrar) H R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 20 1947, at 6 30 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19 1947, to Jan 20 1947 and that I last saw h.. alive on Jan 19 1947

Immediate cause of death	DURATION
Broncho-Pneumonia	
Due to acute Bronchitis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. Herbert Baker M.D. M. D. or other
Address: Elkton Md Date signed: 1/21/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

00458

CERTIFICATE OF DEATH

Reg. Diat. No. 96

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Cecil

City or town: Perryville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Perryville Rural (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Alice C Cooper

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: W. H. Leonard Cooper

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 1, 1870

8. AGE: Years 76 Months 10 Days 17 If less than one day ..... hrs. ..... min.

9. Birthplace: Elkton Cecil, Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: William Taylor

13. Birthplace: Cecil Co. Md

MOTHER 14. Maiden name: Eleanor Jackson

15. Birthplace: Cecil Co. Md.

16. Informant: Dr. H. R. Cooper

Address: Perryville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 20 1947 (month) (day) (year)

Cemetery or crematory: Asbury

Location: Perryville Md. Rural

18. Funeral director: Wm. A. Patterson & Son

Address: Perryville, Md.

19. Jan. 20 1947 (Date rec'd by registrar) Irma E. Dunbar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 18 1947, at 3 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 15 1947 to January 18 1947 and that I last saw h... alive on January 17 1947

Immediate cause of death	DURATION
Cerebral Haemorrhage	3 hrs.
Due to: General atheromata	10 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. F. Magraw M. D. or other

Address: Perryville Md Date signed 1-18-47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932 00453

CERTIFICATE OF DEATH

Reg. Diat. No. 92

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton (Limit Corporate)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 days.

Hospital, institution, or street address where death occurred:

Union Hosp.

How long in hospital or institution? 10 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Pa County: Chester

City or town: Oxford

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Penn Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3. (a) FULL NAME Catherine M Carter

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widow.

6.(b) Name of husband or wife: James Carter.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 20 - 1870

8. AGE:

Years	Months	Days	If less than one day
77 yr.			..... hrs. ..... min.

9. Birthplace: New York.

(Town, county, and state)

10. Usual occupation: Housewife.

11. Industry or business: own home.

FATHER

12. Name: Michael Laughlin

13. Birthplace: N. Y.

MOTHER

14. Maiden name: Mary Shall

15. Birthplace: N. Y.

16. Informant: Francis Fagan

Address: Oxford Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 16 1947 (month) (day) (year)

Cemetery or crematory: St Patricks

Location: West Grove Pa.

18. Funeral director: J. E. Tyson.

Address: Rising Sun Md.

19. Jan 17 1947 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 13 - 1947 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 3 - 1947 to Jan 13 - 1947 and that I last saw h... alive on Jan 13 - 1947

Immediate cause of death	DURATION
Cerebral Embolism	10 days
Due to: Hypertension	2
Due to: Chronic Myocarditis.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Elkton Md. Date signed Jan 14 1947

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00460

832

CERTIFICATE OF DEATH

Reg. Dist. No. 950

1. PLACE OF DEATH:

County: Cecil

City or town: Leeamsto Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DEACEASED:

(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: Leeamsto Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: William M Fulton

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Married

6.(b) Name of husband or wife: Annie Keene

6.(c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): July 13. 1859

8. AGE: Years	Months	Days	If less than one day
87	5	26	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: farming

11. Industry or business

FATHER — 12. Name: Mitchell W. Fulton

13. Birthplace: Pa

MOTHER — 14. Maiden name: Cecelia Osborne

15. Birthplace: Maryland

16. Informant: Mrs Annie Fulton

Address: Conowingo. Md.

17. Burial (Burial, cremation, or removal) Date thereof Jan 13 1947 (month) (day) (year)

Cemetery or crematory: Little Baltimore

Location: Peach Bottom Pa.

18. Funeral director: E. L. Cauffman

Address: Peach Bottom Pa.

19. Jan 11 1947 (Date rec'd by registrar) L. M. Worthington Registrar

Permit issued Jan 11-47.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 9 1947 at 10 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1-9 1947, to 1-9 1947

and that I last saw h alive on 19

Immediate cause of death	DURATION
Hemiplegia a	
Acute Cardiac	
Due to: Arterio sclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: R. L. Rodgers MD (M. D. or other)

Address: Rising Sun Md Date signed 1-10-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1-55

STATE OF MARYLAND—CERTIFICATE OF DEATH 00461

932

1. PLACE OF DEATH

County Cecil Registration Dist. No. 90

Village or City Frederictown md No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Laura Giorgi If U. S. Veteran, specify WAR

(a) Residence: No. Holt mdt St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
female	White	widowed

5a. If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of

6. DATE OF BIRTH (month, day, and year) 4-12-67

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	~~1~~		

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Home wife

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Md (State or country)

FATHER

13. NAME Lawrence Powell

14. BIRTHPLACE (city or town) Pa (State or country)

MOTHER

15. MAIDEN NAME Harriett Farrell

16. BIRTHPLACE (city or town) Del (State or country)

17. INFORMANT Mrs Josephine Biggs
(Address) Fredictown Md.

18. BURIAL, ~~CREMATION~~, OR REMOVAL
Place Townsend Cemetery Date 2-1-47

19. UNDERTAKER G. Gist Daniels
(Address) Townsend Del

20. FILED , 19
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Jan 29 1947
(Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from Jan 28 1947, to Jan 29th 1947
that I last saw her alive on Jan 28th 1947; death is said
to have occurred on the date stated above, at 5:30 A m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

	Date of onset
Coronary occlusion	1-27-47

Other **Contributory Causes** of importance:
Arterio Sclerotic Heart Disease
Senility

Name of operation None Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury , 19

Where did injury occur?
(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Theodore F. Capriochi M. D.

(Address) Galena, Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Preeise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** ete. For a person who had no oceupation whatever write **none.**

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," ete. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "faetory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** ete.

Distinguish earefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** ete. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** ete. Distinguish earefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a **clerk.**

Statement of cause of death.—Cause of death means the disease, injury, or eomplieation which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, ete. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory eauses of importanee, name other important diseases or injuries. Examples:

Example I		**Example II**	
The **principal cause of death** and related causes of importance were as follows:	Date of onset	The **principal cause of death** and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		**Other contributory causes of importance:**	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 108 00462

CERTIFICATE OF DEATH

Reg. Dist. No. 92

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Cecil
City or town: Rural Near Elkton Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, institution, or street address where death occurred:
Elkton R.D. 4
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Cecil Md County: Cecil
City or town: Rural Near Elkton
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.D Dual Highway —
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Susie A. Goutler.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Wh.	Widowed.

6.(b) Name of husband or wife: James Goutler
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): July 27, 1871

8. AGE: Years	Months	Days	If less than one day
75	5	28	____ hrs. ____ min.

9. Birthplace: Cecilton Md (Town, county, and state)
10. Usual occupation: at Home
11. Industry or business

FATHER
12. Name: Robert Register
13. Birthplace: Cecilton Md

MOTHER
14. Maiden name: Laura Jones
15. Birthplace: Baltimore, Md

16. Informant: Mrs Samuel Loller
Address: Middletown, R.D. Del.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 27, 1947 (month) (day) (year)
Cemetery or crematory: Cecilton
Location: Cecilton, Md

18. Funeral director: H.W. Pippin
Address: Elkton, Md

19. Jan 25 1947 (Date rec'd by registrar) F.H. Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 24 1947, at 11 15' A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 10 1948, to Jan. 24 1947
and that I last saw h.er alive on Jan. 24 1947.

Immediate cause of death	DURATION
Lobar pneumonia	Jan. 6
Due to: and Myocardial failure	Jan. 23
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____
Autopsy results: ____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury: ____ Injured at work?

23. SIGNATURE: Mitford N. Sprecher, M.D. M. D. or other
Address: Elkton Date signed: Jan 25 '47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00463

932

Reg. Dist. No. 940

1. PLACE OF DEATH:

County: Cecil

City or town: Rural - North East
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Rural North East
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Catharine A. Greenwood

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	widowed

6.(b) Name of husband or wife: Jerry L. Greenwood

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 4, 1871

8. AGE:

Years	Months	Days	If less than one day
75	6	26	..... hrs. ..... min.

9. Birthplace: Brooklyn, New York
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

MOTHER FATHER

12. Name: Asahel Crossman

13. Birthplace —

14. Maiden name: Sarah A. Burroughs

15. Birthplace —

16. Informant: Alma Greenwood

Address: North East, Md. R.D.

17. Removal (Burial, cremation, or removal. Which?) Date thereof February 4 1947 (month) (day) (year)

Cemetery or crematory: Conoga Cemetery

Location: Canoga, N. Y.

18. Funeral director: Joseph R. Grant

Address: North East, Md.

19. Feb 1 1947 (Date rec'd by registrar) Lisa L. Owens Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 30 January 1947, at 1 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1946 to 30 Jan. 1947

and that I last saw h.e.r. alive on 30 January 1947

	DURATION
Immediate cause of death: Acute pulmonary edema	15 min.
Due to: Hypertensive Cardiovascular Disease	7 years
Due to:	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? — — — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE: Klaus H Huebner M.D.
M. D. or other

Address: North East, Maryland Date signed 30 Jan. 47

VS A15 9.45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1316

CERTIFICATE OF DEATH

00461

Reg. Diat. No. 94

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

1. PLACE OF DEATH:
County Cecil County
City or town North East
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? About 50 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? 50 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Cecil
City or town North East
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war.

3.(a) FULL NAME Edith A Hawkins

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widowed

6.(b) Name of husband or wife William P Hawkins
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 12 1875

8. AGE:

Years	Months	Days	If less than one day
71	1	17	..... hrs. ..... min.

9. Birthplace Lombardville Cecil Co. Md.
(Town, county, and state)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name Washington Brown
13. Birthplace Cecil Co - Md -
MOTHER
14. Maiden name Nancy Jay
15. Birthplace Lancaster, Penn -
16. Informant Mrs. Laura Williams
Address North East, Md -
17. Burial Date thereof Feb. 2 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Cemetery
Location Cedar Hill, Elkton R.D. Md
18. Funeral director Joseph R. Grant
Address North East Md -
19. Feb 1st 1947 Lida B Evans
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 29 1947 at 10 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 4 1947 to Jan. 29 1947
and that I last saw her alive on January 28 1947

Immediate cause of death	DURATION
Coronary Thrombosis	1 day
Due to Arteriosclerosis	3 mos.
Due to	
Due to	
Other conditions Acute Bronchitis	1 week
Chr. pulmonary tuberculosis, healed	10 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James L. Johnson M.D.
M. D. or other
Address Elkton, Md Date signed Jan 30 1947

1-35

00465

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 950

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County Cecil
City or town Rising Sun, Sylmar (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: At Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Cecil
City or town Rising Sun, Rural (If outside city or town limits, write RURAL and give nearest town)
Street No. Sylmar (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mary Isabella Logan
3. (b) Social Security Number

4. Sex: Female
5. Color or race: white
6.(a) Single, married, widowed, or divorced: Widow
6.(b) Name of husband or wife: Walter B Logan
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): June 19, 1862

8. AGE: Years 84 | Months 7 | Days 5 | If less than one day ... hrs. ... min.

9. Birthplace: Leslie Cecil Co Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: Joseph Benjamin
13. Birthplace: Cecil Co md
MOTHER 14. Maiden name: Mary Johnson
15. Birthplace: Cecil Co md.
16. Informant: Wilmer Logan
Address: Rising Sun md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 28 1947 (month) (day) (year)
Cemetery or crematory: North East M.E.
Location: North East Cecil co. Md.
18. Funeral director: Lev A Patterson & Son
Address: Perryville Md.
19 Jan 27 - 19 47 (Date rec'd by registrar) L. M. Worthington Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 24 1947, at 6:10 p.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ... to ... 19 ...
and that I last saw her alive on Jan 24 1947

Immediate cause of death: Congestive heart failure — DURATION 10 days
Due to: Arteriosclerosis
Due to:
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE F. B. Robinson M.D. (M. D. or other)
Address: Oxford, Pa. Date signed 1-24-47

VS A15

Permit Issued 1-27-47

1-55

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

00466

CERTIFICATE OF DEATH

★ Reg. Dist. No. 92

1. PLACE OF DEATH:

County Cecil

City or town Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 31 days

Hospital, Institution, or street address where death occurred:

Union Hospital

How long in hospital or Institution? 31 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Penna. County Chester

City or town Nottingham Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war V

3.(a) FULL NAME David B. McDowell

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Sarah McDowell

6.(c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) March 15 1874

8. AGE: Years	Months	Days	If less than one day
72	8	9	hrs. min.

9. Birthplace Rising Sun, Md. (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Henry Clayton McDowell

13. Birthplace Pa.

MOTHER 14. Maiden name Mary Gifford

15. Birthplace Md.

16. Informant Mrs. David McDowell

Address Nottingham, Pa. R. D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 28 1947 (month) (day) (year)

Cemetery or crematory Friends Burying Ground

Location Near Rising Sun, Md.

18. Funeral director J. C. Tyson

Address Rising Sun Md.

19. Jan 26 1947 (Date rec'd by registrar) F R Frazer (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 24th 1947, at 9.20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 23rd 1946 to Jan 24 1947

and that I last saw h.. alive on January 24 1947

Immediate cause of death Acute Myocarditis

Due to Coronary Disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Acute Myocarditis 1 mo.

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. C. Tyson M.D. M. D. or other

Address Elkton Md. Date signed Jan 26 1947

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

00467

CERTIFICATE OF DEATH

Reg. Dist. No. 426

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 da

Hospital, Institution, or street address where death occurred: Union Hospital

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Cecil

City or town: Elkton, Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Baby Girl McLaughlin (Martha Ellen)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Wh.	Single.

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 7, 1947

8. AGE: Years | Months | Days: 2 | If less than one day: hrs. min.

9. Birthplace: Elkton, Md (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER 12. Name: James McLaughlin

13. Birthplace: Anton W. Va

MOTHER 14. Maiden name: Mary Evans

15. Birthplace: Roosevelt, W. Va

16. Informant: James McLaughlin

Address: #46 Hollingsworth Motor Elkton, Md

17. Burial. (Burial, cremation, or removal. Which?) Date thereof Jan. 11/47 (month) (day) (year)

Cemetery or crematory: Elkton

Location: Elkton, Md

18. Funeral director: H. W. Pippin

Address: Elkton, Md

19. Jan 11 1947 (Date rec'd by registrar) J R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: ~~Jan~~ Jan. 9 1947 at 6 45 P. M.

21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from Jan. 7 1947, to Jan. 9 1947

and that I last saw h... alive on Jan. 9 1947

Immediate cause of death	DURATION
Anasarca	
Due to: Prematurity	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Mitford H. Spreaker, M.D. M. D. or other

Address: Elkton, Md Date signed: Jan. 10'47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

61

00468

Reg. Dist. No. 960

1. PLACE OF DEATH:

County: CECIL

City or town: PERRY POINT, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs. 11 mos. 1 day

Hospital, Institution, or street address where death occurred:
Veterans Administration Hospital, Perry Point, Md.

How long in hospital or institution? 4 yrs. 11 mos. 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: PENNA. County:

City or town: Wyncote
(If outside city or town limits, write RURAL and give nearest town)

Street No. Hewitt Road & Glenview Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: MENGEL, Edith May

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: --

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): March 22, 1882

8. AGE:

Years	Months	Days	If less than one day
64	9	14	____ hrs. ____ min.

9. Birthplace: Pine Grove, Pa.
(Town, county, and state)

10. Usual occupation: Nurse

11. Industry or business:

FATHER — 12. Name: Unknown - deceased

13. Birthplace: Unknown

MOTHER — 14. Maiden name: Unknown - deceased

15. Birthplace: Unknown

16. Informant: Hospital Records, Perry Point, Md.

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 8, 1947 (month) (day) (year)

Cemetery or crematory: Pine Grove Lutheran Cemetery

Location: Philadelphia, Pa.

18. Funeral director: H.B. Mulligan
H.B. MULLIGAN
Address: 1119 W. Lehigh, Philadelphia, Pa.

19. Jan 6 1947 (Date rec'd by registrar) Irene E. Doughty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 5 1947, at 9:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 4 1942 to Jan. 5 1947 and that I last saw her alive on January 5 1947

	DURATION
Immediate cause of death: Myocardial degeneration	One year
Due to: Coronary arteriosclerosis	One year
Due to:	
Other conditions: 1. Diabetes mellitus; 2. Dementia Praecox, Paranoid type (Include pregnancy within 3 months of death)	1. Over 1 yr. 2. Unknown

Major findings of operations: --

Date of op.:

Autopsy results: --

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: -- Date of:

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): --

Means of injury: -- Injured at work?

23. SIGNATURE: A. E. Strecker M. D. or other

Address: A. E. TROLLINGER, M.D., Clinical Director VAH, Perry Point, Md. Date signed: 1-6-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9.45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00463

131a

CERTIFICATE OF DEATH

Reg. Dist. No. 960

1. PLACE OF DEATH:

County: Cecil

City or town: Port Deposit

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 46 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Port Deposit

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: William Henry Newman

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Mae Newman

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 3, 1871

8. AGE: Years	Months	Days	If less than one day
75	10	0	..... hrs. ..... min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Day

FATHER — 12. Name: William H. Newman

13. Birthplace: Va.

MOTHER — 14. Maiden name: Martha Fandroy

15. Birthplace: Va.

16. Informant: Mae Newman

Address: Port Deposit, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 6, 1947 (month) (day) (year)

Cemetery or crematory: Mount Zoar

Location: Conowingo, Md., Rural

18. Funeral director: Lewis A. Patterson & Son

Address: Perryville, Md.

19. Jan. 6 1947 (Date rec'd by registrar) Irma E. Langford Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 3 1947, at 1230 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 1946, to January 3 1947

and that I last saw h.. alive on January 3 1947

Immediate cause of death	DURATION
Cerebral Hemmorhage	1
Due to: Arteri Sclerosis	10 yrs.
Due to: Chronic intestinal nephritis	10 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Irma Mallett M.D. M. D. or other

Address: Havre de Grace Date signed Jan 7, 1947

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9/ 00479

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Cecil

City or town: Chesapeake City

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred: Chesapeake City at Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Cecil

City or town: Chesapeake City

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Annie Rebecca Reaper

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Wh	Married

6.(b) Name of husband or wife: William Reaper

6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): Oct 9, 1891

8. AGE: Years	Months	Days	If less than one day
55	3	3	...hrs. ...min.

8. Birthplace: Chesapeake City, Md (Town, county, and state)

10. Usual occupation: at Home

11. Industry or business

FATHER — 12. Name: John Amos

FATHER — 13. Birthplace: Pleasant Hill, Md

MOTHER — 14. Maiden name: Sarah Robinson

MOTHER — 15. Birthplace: Chesapeake City, Md

16. Informant: William Reaper

Address: Chesapeake City, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 15, 1947 (month) (day) (year)

Cemetery or crematory: Bethel

Location: Chesapeake City, Md RD

18. Funeral director: H. W. Pippin

Address: Elkton, Md

19. January 10, 1947 (Date rec'd by registrar) Wm. Rapley D. Reg. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 12, 1947, at 6:00 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April, 1945, to Jan 12, 1947 and that I last saw h[illegible] alive on January 12, 1947

Immediate cause of death	DURATION
Hypertensive Cardiovascular Renal disease	1½ months
Due to	
Due to	
Other conditions Oedema of extremities	6 months

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: N.D. Date of

Where did injury occur? No (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. E. Davis M.D. M. D. or other

Address: Chesapeake City Md Date signed: 1/13/47

1-25

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00471

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: Cecil

City or town: Perry Point, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 yrs. 10 mos. 22 days

Hospital, institution, or street address where death occurred:
Veterans Administration Hospital
Perry Point, Md.

How long in hospital or institution? 8 yrs. 10 mos. 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2616 N. Calvert Street
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3. (a) FULL NAME: PRICE, William Albert Jr.

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: --

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): February 11, 1900

8. AGE: Years	Months	Days	If less than one day
46	10	21	..... hrs. ..... min.

9. Birthplace: Jarrettsville, Maryland
(Town, county, and state)

10. Usual occupation: Student

11. Industry or business

FATHER — 12. Name: William A. Price - deceased

13. Birthplace: Baltimore Co., Md.

MOTHER — 14. Maiden name: Anna Dudek - deceased

15. Birthplace: New York City

16. Informant: Hospital Records

Address: Veterans Administration Hospital
Perry Point, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 4, 1947 (month) (day) (year)

Cemetery or crematory: Chestnut Grove Church Cemetery

Location: Sweet Air, Baltimore County, Md.

18. Funeral director: E. G. KURTZ & SON

Address: Jarrettsville, Md.

19. Jan. 2, 1947 (Date rec'd by registrar) Irene E. Daugherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 2 19 47, at 7:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 10 19 38, to January 2 19 47 and that I last saw him alive on January 2 19 47

Immediate cause of death	DURATION
Tuberculosis, pulmonary, chronic, active, far advanced	Aug. 1943
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: --

Date of op.

Autopsy results: --

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: -- Date of

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): --

Means of injury: -- Injured at work?

23. SIGNATURE: A. E. TROLLINGER, M.D., Clinical Director
(Official capacity or other)

Address: VAH, Perry Point, Md. Date signed: 1-2-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

00472

CERTIFICATE OF DEATH

Reg. Dist. No. 920

1. PLACE OF DEATH: County: Cecil; City or town: Elkton (If outside city or town limits, write RURAL and give nearest town); How long in above place of death? 12 hrs; Hospital, Institution, or street address where death occurred: Union Hospital; How long in hospital or institution? 12 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Chesapeake City (If outside city or town limits, write RURAL and give nearest town)
Street No.: Biddle (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Nellie Beaston Reed

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Widowed

6.(b) Name of husband or wife: Lex Reed
6.(c) If alive, give age: yesrs

7. Birth date of deceased (mo., day, yr.): May 9 1877

8. AGE: Years	Months	Days	If less than one day
~~70~~ 69	7	21	hrs. min.

9. Birthplace: Queen Anne Co. (Town, county, and state)
10. Usual occupation: at Home
11. Industry or business

FATHER
12. Name: Andrew Beaston
13. Birthplace: Cecil Co. Md

MOTHER
14. Maiden name: Catherine Manner
15. Birthplace: Chesapeake City, Md

16. Informant: Mrs Ethel Beaston
Address: Chesapeake City, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 4, 1947 (month) (day) (year)
Cemetery or crematory: Bethel
Location: Nr. Chesapeake City, Md
16. Funeral director: H. W. Lippincott
Address: Elkton, Md

18. Jan 4 1947 (Date rec'd by registrar) F R Brazier Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 1 1947, at 7:32 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from December 31 1946 to Jan. 1 1947
and that I last saw h... alive on Dec. 31 1946

Immediate cause of death	DURATION
Congestive heart failure	A few hrs.
Due to: Generalized arteriosclerosis;	9 mos.
Cardio-vascular-renal disease;	?
Due to: Auricular fibrillation	
Other conditions: Diabetes mellitus	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: S. Ralph Hendrickson Jr. M. D. or other
Address: 233 E. Main - Elkton, Md Date signed: Jan 1, 1947

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00473

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: CECIL

City or town: PERRY POINT, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mos. 19 days

Hospital, institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.

How long in hospital or institution? Since June 24, 1946

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1741 Swann Street, N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: ROLLINS, James A.

3.(b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Negro	Married

6.(b) Name of husband or wife: Nettie Turner Rollins

6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): July 9, 1890

8. AGE: Years	Months	Days	If less than one day
56	6	22	..... hrs. ..... min.

9. Birthplace: Bel Air, Maryland
(Town, county, and state)

10. Usual occupation: Unknown

11. Industry or business:

FATHER — 12. Name: John Rollins

13. Birthplace: Unknown

MOTHER — 14. Maiden name: Unknown

15. Birthplace: Unknown

16. Informant: Hospital Records

Address: VAH, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Jan. 22, 1947 (month) (day) (year)

Cemetery or crematory: Arlington Nat'l Cemetery

Location: Fort Myer, Virginia

18. Funeral director: Mrs. George H. Holland pro tem
MRS. GEORGE H. HOLLAND

Address: 1631 Druid Hill Ave.
Baltimore, Maryland

19. Jan. 22 1947 (Date rec'd by registrar) Irene E. Daughaday Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 21 1947 at 2:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 2 1946, to Jan. 21 1947 and that I last saw him alive on January 21 1947

Immediate cause of death	DURATION
Coronary occlusion	Approx. 2 dys
Due to:	
Due to:	
Other conditions: Dementia Praecox, Paranoid type (Include pregnancy within 3 months of death)	Unknown

Major findings of operations: --

Date of op.:

Autopsy results: --

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: -- Date of:

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): --

Means of injury: -- Injured at work?

23. SIGNATURE: A. E. Trollinger M. D. or other
A. E. TROLLINGER, M.D.
Clinical Director
Address: VAH, Perry Point, Md. Date signed: 1-22-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45 15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00474

46e

CERTIFICATE OF DEATH

Reg. Dist. No. 9/

1. PLACE OF DEATH:

County: Cecil

City or town: Chesapeake City.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, institution, or street address where death occurred: Chesapeake City, Md

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: Chesapeake City Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Walter Sapp.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Wh	Married

6.(b) Name of husband or wife: Lydia S. Sapp

6.(c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) Jan 26, 1875

8. AGE: Years	Months	Days	If less than one day
71	11	17	....hrs. ....min.

9. Birthplace: Church Hill, Md (Town, county and state)

10. Usual occupation: Retd Farmer

11. Industry or business

FATHER — 12. Name: John Sapp.

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Rebecca Galt.

MOTHER — 15. Birthplace: Summit Bridge, Del.

16. Informant: Mrs Sidsal S. Sapp

Address: Chesapeake City, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 16, 1947 (month) (day) (year)

Cemetery or crematory: Bethel

Location: Near Cheswold, Delaware

18. Funeral director: H. W. Pippin

Address: Elkton, Md

19. January 15 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 13 1947 at 11-15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 10 1946 to Jan 13 1947

and that I last saw h[illegible] alive on Jan. 13 1947

Immediate cause of death	DURATION
Carcinoma of Colon	2 years
Due to: Metastases	6 months
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of ascending Colon Date of op. ?

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Henry F Davis M.D. M. D. or other

Address: Chesapeake Md Date signed 1/13/47

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

00475

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:
County Cecil
City or town Bainbridge, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 Yrs.
Hospital, institution, or street address where death occurred:
U.S.N. Hospital Bainbridge, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Cecil
City or town Bainbridge
(If outside city or town limits, write RURAL and give nearest town)
Street No. Bldg 912 apt 3 Naval Housing
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Quenton Eugene Slone

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	

6.(b) Name of husband or wife none

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) January 8 1947

8. AGE: Years | Months | Days | If less than one day: 5 hrs. 54 min.

9. Birthplace Bainbridge, Md. Cecil County
(Town, county, and state)

10. Usual occupation Newborn

11. Industry or business

FATHER
12. Name Harold Ezra Slone
13. Birthplace Hardy Kentucky

MOTHER
14. Maiden name Dorothy Phyllis Burnett
15. Birthplace Conrad Montana

16. Informant Harold Ezra Slone (Father)
Address Apt 3 Bldg 912, Naval Housing, Bainbridge, Md.

17. Cremation Date thereof 1 6 47
(Burial, cremation, or removal. Which?) (month) (day) (year)
~~Cemetery~~ or crematory U.S. Naval Hospital
Location Bainbridge, Md.

18. Funeral director Lieut. W. J. Stanley
Address U.S.N. Hospital, Bainbridge, Md.

19. Jan. 4 1947 Irene E. Langhorst
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 Jan. 1947, at 2 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3 Jan. 1947, to 4 Jan. 1947 and that I last saw h.e.i.m. alive on 4 Jan 1947

Immediate cause of death	DURATION
Prematurity	
(7 calander month	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results Same

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Graham R. Johnston (Dr. (M.C.) U.S.N.
M. D. or other
Address O.P.D., U.S.N.T.C. Bainbridge Md. Date signed 4 Jan 47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00476

Reg. Dist. No. 96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: CECIL
City or town: Perry Point, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 days
Hospital, Institution, or street address where death occurred:
Veterans Administration Hospital, Perry Point, Md.
How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 123 N. Luzerne Street
(If rural, give LOCATION)
2.(a) If veteran, name war: Unknown

3. (a) FULL NAME: SNYDER, Ralph

3. (b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: --
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Unknown 1904

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
43				

9. Birthplace: Latvia (Town, county, and state)
10. Usual occupation: Sheet Metal Worker
11. Industry or business:
FATHER 12. Name: Abraham
13. Birthplace: Latvia
MOTHER 14. Maiden name: Hannah
15. Birthplace: Latvia
16. Informant: Hospital Records, VAH, Perry Point, Maryland
Address:
17. Removal - Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 6, 1947 (month) (day) (year)
Cemetery or crematory: Rosedale
Location: Philp Rd & Hamilton Ave
18. Funeral director: Jack Lewis Inc
Address: JACK LEWIS, Inc. 2100 Eutaw Place Baltimore, Maryland
19. Jan 6 1947 (Date rec'd by registrar) Irene E. Daugherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 6 19 47 at 6:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 30 19 46 to Jan. 6, 19 47 and that I last saw him alive on January 6 19 47

Immediate cause of death	DURATION
Thrombosis of right popliteal artery	Unknown
Due to:	
Due to:	
Other conditions: Gangrene of right leg (Include pregnancy within 3 months of death)	Unknown

Major findings of operations: --
Date of op.:
Autopsy results: --
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of:
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): --
Means of injury: -- Injured at work?

23. SIGNATURE: V.J. COVALESKY, M.D., Acting Clin. Director (M.D. or other)
Address: VAH, Perry Point, Md. Date signed: 1-6-47

1-35

00477

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

Reg. Dist. No. 920

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Two Days

Hospital, institution, or street address where death occurred: Union Hospital

How long in hospital or institution? Two Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Rowlandville, Md. Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Helen Rowland Squier

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: J. Wilson Squier

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 14, 1860

8. AGE: Years	Months	Days	If less than one day
86			..... hrs. ..... min.

9. Birthplace: Rowlandville, Cecil Co., Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Dr. William B. Rowland

13. Birthplace: Cecil Co., Md.

MOTHER — 14. Maiden name: Cassandra F. Sappington

15. Birthplace: Harford Co., Md.

16. Informant: Mrs. David T. Carter

Address: 2107 Carterdale Rd. Balto. 9, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 15, 1947 (month) (day) (year)

Cemetery or crematory: West Nottingham

Location: Colora, Md. Rural

18. Funeral director: Lee A. Patterson & Son

Address: Perryville, Md.

19. Jan 15 1947 (Date rec'd by registrar) J R Fraser (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 12 1947 at 7.20 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 10 1947, to January 12 1947, and that I last saw h.. alive on January 12 1947

Immediate cause of death	DURATION
Cerebral apoplexy	36 hrs.
Due to: General Atheromata	10 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. F. Magraw M. D., or other

Address: Perryville Md Date signed 1-17-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

92d DC

00478

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: CECIL

City or town: PERRYVILLE, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 mos. 2 days

Hospital, institution, or street address where death occurred:
Veterans Administration Hospital, Perry Point, Md.

How long in hospital or institution? Unknown

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 909 Cathedral Street
(If rural, give LOCATION)

2.(a) If veteran, name war: PT & WW-I

3.(a) FULL NAME: STEIGLEMAN, Harry F. (Howard)

3.(b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Single

6.(b) Name of husband or wife: --

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October 8, 1888

8. AGE: Years	Months	Days	If less than one day
58	3	23	..... hrs. ..... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: Unknown - deceased
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown - deceased
15. Birthplace: Unknown

16. Informant: Hospital Records, VAH, Perry Point, Md.

Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof Jan. 31, 1947 (month) (day) (year)

Cemetery or crematory: Louden Park Cemetery

Location: Baltimore, Md.

18. Funeral director: Wm. J. Tickner & Sons Rec'd
WM. J. TICKNER & SONS

Address: Penna. & North Ave., Baltimore, Md.

19. Jan. 31 1947 (Date rec'd by registrar) Irene E. Dougherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 31 1947, at 9:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 29 1946, to Jan. 31 1947 and that I last saw him alive on January 31 1947.

Immediate cause of death	DURATION
Chronic endocarditis	3½ months
Due to: Coronary Arteriosclerosis	Unknown
Due to: Generalized arteriosclerosis	Unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: -- Date of .....

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): --

Means of injury -- Injured at work?

23. SIGNATURE: A. E. Trollinger M.D. or Other

Address: VAH, Perry Point, Md. Date signed: 1-31-47

A. E. TROLLINGER, M.D., Clinical Director

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1376

0042

CERTIFICATE OF DEATH

Reg. Dist. No. 62

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 wks

Hospital, Institution, or street address where death occurred:

Union Hospital

How long in hospital or institution? 6 wks.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: C Rural near Chesapeake City

(If outside city or town limits, write RURAL and give nearest town)

Street No.: R.D.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Avery Tribbett

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Wh	Widowed

6.(b) Name of husband or wife: Mary A Tribbett

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 17, 1860

8. AGE:

Years	Months	Days	If less than one day
86	1	7	..... hrs. ..... min.

9. Birthplace: New Dover Del (Town, county, and state)

10. Usual occupation: Retd Farmer

11. Industry or business:

FATHER

12. Name: John Tribbetts

13. Birthplace: Greensborough Md

MOTHER

14. Maiden name: Liza Ann Jewell

15. Birthplace: Maryland

16. Informant: John R. Tribbetts

Address: Chesapeake City R.D. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 27, 1947 (month) (day) (year)

Cemetery or crematory: Bonnette Chapel

Location: New Dover Del

18. Funeral director: H.W. Pippin

Address: Elkton, Md

19. Jan 25 1947 (Date rec'd by registrar) H Frazer (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 24 January 1947, at 2 05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 10 1946, to Jan 24 1947

and that I last saw h[illegible] alive on Jan 24 1947

Immediate cause of death: Leukemia — DURATION: Dec 10 1946

Due to: Chronic Frostbite — DURATION: several years

Due to: .....

Other conditions: .....

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: H. Davis M.D. M. D. or other

Address: Chesapeake City Md Date signed: 1/24/47

1 - 35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932 00480

Reg. Dist. No. 92

1. PLACE OF DEATH:

County Cecil

City or town Newark Del R.D. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 34 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Cecil

City or town Newark R.D. (If outside city or town limits, write RURAL and give nearest town)

Street No. Rural (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Joseph Trubiar

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widower

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Mar 19 - 1847

8. AGE: Years	Months	Days	If less than one day
99	10	5	hrs. min.

9. Birthplace Bohemia (Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER 12. Name Frank Trubiar

13. Birthplace Bohemia

MOTHER 14. Maiden name Marie Zvolanek

15. Birthplace Bohemia

16. Informant Frank Trubiar

Address Newark Del R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 29 1947 (month) (day) (year)

Cemetery or crematory White Clay Creek Del

Location near Newark Del

18. Funeral director R. J. Jones

Address Newark Del

19. Jan 28 1947 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 24 1947, at 11:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JAN 24 1947 to JAN 24 1947 and that I last saw h(IM) alive on JAN 24 1947

	DURATION
Immediate cause of death HEART FAILURE	1 DAY
Due to ARTERIOSCLEROTIC HEART DISEASE	30 YRS
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William C. Schumann M.D. M. D. or other

Address Academy Apts Newark Del Date signed 1/25/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00481

46a

Reg. Dist. No. 950

1. PLACE OF DEATH:

County: Cecil

City or town: Rising Sun

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1½ yrs.

Hospital, Institution, or street address where death occurred: Mount st. Rising Sun

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil Co

City or town: Rising Sun Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Alexander Wilson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	white	married

6.(b) Name of husband or wife: Ruth West

6.(c) If alive, give age: 80 years

7. Birth date of deceased (mo., day, yr.): Oct 12. 1871

8. AGE:

Years	Months	Days	If less than one day
75	3	13	hrs. min.

9. Birthplace: Barnsley, Pa (Town, county, and state)

10. Usual occupation: Railroad agent

11. Industry or business: Railroad

FATHER

12. Name: Alexander Wilson

13. Birthplace: Edenburgh, Scotland

MOTHER

14. Maiden name: Margaret Ferguson

15. Birthplace: Glasgow, Scotland

16. Informant: Ruth Wilson

Address: Rising Sun. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 29 1947 (month) (day) (year)

Cemetery or crematory: Gallingham Friends

Location: Colora, Md.

18. Funeral director: C.E. Tyson.

Address: Rising Sun Md.

19. Jan 27 1947 (Date rec'd by registrar) Registrar

Certificate received 1-29-47

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 24 1947, at 8 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 1946, to Jan 25 1947

and that I last saw h... alive on Jan 25 1947

Immediate cause of death: Carcinoma of Sigmoid — DURATION: ?

Due to:

Due to:

Other conditions: Hepatic metastisis — DURATION: 3 months

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [illegible] M. D. or other

Address: [illegible] Pa. Date signed Jan 26 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35